SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*41861*
Company Tracking Number:	*GH AR0150001F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Retiree Markets*		
Project Name/Number:	*2009 Retiree Markets/GH AR0150001F01*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2009 Retiree Markets	SERFF Tr Num: AENX-126079802	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 41861
Sub-TOI: H21.000 Health - Other	Co Tr Num: GH AR0150001F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 03/25/2009
	Date Submitted: 03/18/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Retiree Markets	Status of Filing in Domicile: Authorized
Project Number: GH AR0150001F01	Date Approved in Domicile: 02/12/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 03/25/2009	Explanation for Other Group Market Type:
	State Status Changed: 03/25/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

These new forms have been developed to support a product designed for retirees who have enrolled in Medicare Parts A and B for their primary health care coverage. The product design is simple in that coverage is provided for a portion of the Medicare plan's cost-sharing and for services and supplies which may be covered once Medicare limits have been exhausted. Though this is not a Medicare Supplement health plan, you will find that the plan of benefits mirrors those available in such plans.

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Company and Contact

Filing Contact Information

Doreen Gatley, P&RA Support Specialist
151 Farmington Avenue
Hartford, CT 06156

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Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name: Aetna
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$50.00	03/18/2009	26504018

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/25/2009	03/25/2009

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
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Disposition

Disposition Date: 03/25/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	CERTIFICATE EOV	Approved-Closed	Yes
Supporting Document	SCHEDULE OF BENEITS EOV	Approved-Closed	Yes
Supporting Document	Attachment A	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	NAIC Form Listing	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	CERTIFICATE OF COVERAGE	Approved-Closed	Yes
Form	SCHEDULE OF BENEFITS	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: GR-9N-GM 01-005 01

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-9N-GM 01-005 01	Certificate	CERTIFICATE OF COVERAGE	Initial		42	GR-9N-GM 01-005 01.PDF
Approved-Closed	GR-9N-GM S-10-01	Schedule Pages	SCHEDULE OF BENEFITS	Initial		0	GR-9N-GM S-10-01.PDF

Table of Contents

Preface

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the **Policyholder**. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the **Policyholder** to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The **Policyholder** selects the products and benefit levels under the plan. A person covered under this plan is subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

This is not a Medicare supplement insurance plan.

[**Policyholder**:	ABC Company
Policy Number:	XXXXXX
Policy Effective Date:	January 1, 20XX
Renewal Effective Date:	January 1, 20XX
Issue Date:	January 1, 20XX
Booklet-Certificate Number:	1]

[Ronald A. Williams
Chairman, Chief Executive Officer and President]

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including **hospitals**, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the **retired employee** or the covered dependent.

Who Can Be Covered - Eligibility

To be covered by this plan, the following requirements must be met:

§ You will need to be in an "eligible class," as defined below; and
§ You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an Eligible Class if you are:

§ [A retired employee who had at least 5 years of service as an employee with a **Participating Employer** or an employer currently affiliated with the **Participating Employer** due to a merger or acquisition;
§ no longer a full-time or part-time employee of the **Participating Employer**, as such is defined under the Internal Revenue Code; and
§ otherwise eligible to participate in the **Participating Employer**'s retirement benefits program; or
§ a dependent of a **covered retired employee**; and you are:
  - Age 65 or older and you are enrolled in **Medicare Part A** (**Hospital** Insurance) and **Medicare Part B** (Medical Insurance), and continue to pay the **Medicare Part B** premium and **Medicare Part A** premium, if applicable; [or
  - Less than age 65 and eligible for **Medicare** due to disability excluding End Stage Renal Disease (ESRD) with the exception of the first 30 months of **Medicare** entitlement due to End Stage Renal Disease (ESRD) and enrolled in **Medicare Part A** (**Hospital** Insurance) and **Medicare Part B** (Medical Insurance), and continue to pay the **Medicare Part B** premium and **Medicare Part A** premium, if applicable.]

§ [You are a dependent if you are a spouse, domestic partner of the same or different gender, dependent child of the **covered retired employee** and meet the eligibility criteria above and the eligibility requirements set by the **covered retired employee's** former employer.]

[No person may be covered both as a **covered retired employee** and dependent. No person may be covered as a dependent by more than one **covered retired employee**.]

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an Eligible Class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is [the first day of the calendar month following the date you enter the eligible class].

[Important Reminder
Keep in mind that you cannot receive coverage under the plan as:

§ Both a **covered retired employee** and a dependent; or
§ A dependent of more than one **covered retired employee**.]

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and the **Policyholder**. To complete the enrollment process, you will need to provide all requested information. You will also need to agree to make required contributions for any contributory coverage. The **Policyholder** will determine the amount of your plan contributions, which you will need to agree to before you can enroll. The **Policyholder** will advise you of the required amount of your contributions [and will deduct your contributions from your pay.] Remember plan contributions are subject to change.

[You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.]

If you do not enroll for coverage when you first become eligible, but wish to do so later, the **Policyholder** will provide you with information on when and how you can enroll.

Late Enrollment

If you do not enroll during the Initial Enrollment period, or a subsequent annual enrollment period, you may be considered a Late Enrollee.

You must return your completed enrollment information before the end of the next annual enrollment period.

[However, you may not be considered Late Enrollees under the circumstances described in the *Special Enrollment Periods* section below.]

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

[Special Enrollment Periods

You will not be considered a Late Enrollee if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You may qualify for a Special Enrollment Period if:

- You did not enroll when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you had other **creditable coverage**; and
- You are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment or employment of the **covered retired employee**;
  - A reduction in your hours of employment or a reduction in the hours of employment of the **covered retired employee** (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The **Policyholder**'s decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of your status as being in an eligible classes such is defined under this Plan; or
- You will need to enroll for coverage within 31 days of when other **creditable coverage** ends. Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.]

[New Dependents

If you are a **covered retired employee**, your dependents may qualify for a Special Enrollment Period if:

- You later acquire a dependent, as defined under the plan, or
- Your dependents later meets all of the requirements to be in an eligible class as described in the *Eligibility* section of this *Booklet-Certificate.*

You will need to report any new dependents by completing a change form, which is available from the **Policyholder**. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.]

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement.

Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment. Any coverage limitations for a **pre-existing condition** will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within [31] days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a **pre-existing condition** will not apply, as long as you submit a written request for coverage within the [31]-day period.

If you do not request coverage for the child within the [31]-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- [If you are a retired employee and you retired on or before the date your employer became a participant in the RHA Program, the date your employer became a **Participating Employer** in the RHA Program; or
- If you are a retired employee and you retired after the date your employer became a participant in the RHA Program, the date you retired; or]
- The date you return your completed enrollment information; and
- The date your required contribution is received by **Aetna**.

If you do not return your completed enrollment information within [31] days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full.

[Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

If you are an eligible dependent of a **covered retired employee** and the **covered retired employee** retired on or before the date the **covered retired employee's** employer became a participant in the **RHA program**, your coverage will take effect as of the date the employer became a participating employer in the **RHA program**; or if you are an eligible dependent of a **covered retired employee** and the **covered retired employee** retired after the date the employer became a participant in the **RHA program**, your coverage will take effect on the date the **covered retired employee** retired.

If you acquire a new dependent, coverage for such newly acquired dependent will take effect [no later than the first day of the first month beginning after the date **Aetna** receives the request of the enrollment in the case of a new spouse or dependent acquired through marriage] [retroactively to the date of birth, adoption, or placement for adoption of such newly acquired dependent.]

If you defer enrolling your dependents, you may not add such dependents at a later date.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Period* section will apply.]

How Your Medical Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This *Booklet-Certificate* explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Your health plan pays benefits only for services and supplies described in this *Booklet-Certificate* as **covered expenses** that are **medically necessary**.
- You must use a health benefits provider that is eligible to receive reimbursement under **Medicare** in order to receive benefits under this Plan [except for certain **medically necessary emergency care** received in foreign countries while traveling]. This Plan covers only **Medicare** approved charges, up to the **Medicare** allowable amount, unless otherwise noted in the *Schedule of Benefits*.
- This *Booklet-Certificate* applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this *Booklet-Certificate* in a safe place for future reference.

Common Terms

Many terms throughout this *Booklet-Certificate* are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Medical Plan

This **Aetna** medical plan does not provide benefits for all medical care.

The plan will pay for **covered expenses** up to the maximum benefits shown in the *Schedule of Benefits*. Coverage is subject to all the terms, policies and procedures outlined in this *Booklet-Certificate*. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions*, *Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded, or limited.

Using the Plan

§ When you need medical care, you can directly access **physicians**, **hospitals** and other health care providers that are eligible to receive payment under **Medicare** for covered services and supplies under the plan.

§ You may have to pay the provider or facility and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the provider. **Aetna** will reimburse you for a **covered expense** up to the **recognized cost**, less any cost sharing required by you.

§ [You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **coinsurance** or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail.]

Cost Sharing

Important Note:
You share in the cost of your care. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

§ [You must satisfy any applicable **deductibles** before the plan begins to pay benefits.]
§ [After you satisfy any applicable **deductible**,] you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **out-of-pocket maximum** applicable to your plan.
§ Your **payment percentage** will be based on the **recognized cost**. If the health care provider you select charges more than the **recognized cost**, you will be responsible for any expenses above the **recognized cost**
§ Once you satisfy the **out-of-pocket maximum**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar year. Certain designated out-of-pocket expenses may not apply to the **payment limit**. Refer to your *Schedule of Benefits* section for information on what expenses do not apply to the limit and specific dollar limits that apply to your plan.
§ The plan will pay for **covered expenses**, up to the maximums shown in the *Schedule of Benefit* section. You are responsible for any expenses incurred over the maximum limits outlined in the *Schedule of Benefits* section.

[In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.

Follow-Up Care After Treatment of an Emergency Medical Condition

Follow-up care is not considered an **emergency condition**. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.]

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:

   - § Be included as a **covered expense** in this *Booklet-Certificate*;
   - § Not be an excluded expense under this *Booklet-Certificate*. Refer to the *Exclusions* sections of this *Booklet-Certificate* for a list of services and supplies that are excluded;
   - § Not exceed the maximums and limitations outlined in this *Booklet-Certificate*. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - § Be obtained in accordance with all the terms, policies and procedures outlined in this *Booklet-Certificate*.

2. The service or supply must be provided while coverage is in effect. See the *Eligibility, Enrollment and Effective Date of Coverage*, *When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply must be **medically necessary**. To meet this requirement, the medical services or supply must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, **disease** or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or **disease**; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or **disease**.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service or supply that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

Health Expense Coverage

This plan covers medical services and supplies that are recognized as reasonable and **medically necessary** by **Medicare** for the diagnosis, care or treatment of the **disease** or **injury** involved. This applies even if they are prescribed, recommended or approved by the person's attending **physician**.

Except as described in the extended benefits provision, no benefits are payable for expenses incurred before coverage has commenced or after coverage has ended. An expense for a service or supply is incurred on the date the service or supply is furnished.

Categories of Covered Medical Expenses are described below. The plan is subject to [a **deductible** and] exclusions.

NOTE: You must use a health care provider who is eligible to receive reimbursement from **Medicare** in order to receive benefits under this plan. With the exception of inpatient **hospital** expenses for 365 days after **Medicare** benefits are exhausted [and certain **medically necessary emergency care** received in foreign countries while traveling] this plan covers only **Medicare** approved charges up to the **Medicare** allowable amount.

The *Schedule of Benefits* describes the actual benefits that apply to the categories of **covered expenses** described below.

NOTE: You must use a health care provider who is eligible to receive reimbursement under **Medicare** in order to receive benefits under this Plan [except for certain **medically necessary emergency care** received in foreign countries while traveling]. This Plan covers only **Medicare** approved charges, up to the **Medicare** allowable amount unless otherwise noted in the *Schedule of Benefits*.

This Plan provides for automatic adjustment of benefits necessary to cover changes in the [coinsurance amount, deductible or coverage requirements] of the Medicare program. Changes to Part A and Part B of Medicare are generally announced in October to take effect on the first day of January of the following calendar year. Aetna will provide notice of any resulting changes in benefits or premium contributions. Any changes required will become effective on the effective date of the change in the Medicare program.

Covered Expenses

[Listed below are categories of **covered expenses** for certain **hospital** and other medical services and supplies that may be covered under this plan. They must be for the treatment of an **injury** or **disease**. Please refer to the *Schedule of Benefits* for a description of the actual benefits covered under this plan for each category of medical services and supplies listed below. **Aetna** will provide coverage up to the maximum benefit for all services and supplies as set forth on the *Schedule of Benefits*.

- **Hospitalization** Services
- Inpatient Mental Health
- Skilled Nursing Facility Care
- Blood
- Part B Medical Services
- **Durable Medical Equipment**
- Part B **Excess Fees**
- Foreign Travel Emergency]

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY!

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate*.

- [Care received outside the United States unless specifically listed in the *Schedule of Benefits.*
- Charges not covered by **Medicare**, except to the extent shown in the *Schedule of Benefits*.
- Charges in excess of the amounts approved by **Medicare**, except to the extent shown in the *Schedule of Benefits*.
- Charges for the treatment of the mouth, jaws or teeth, unless considered an allowable **Medicare** expense.
- Charges for speech, physical and occupational therapy in excess of the **Medicare** allowed amount.
- Cosmetic surgery, except that cosmetic surgery will not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other **diseases** of the involved part, and reconstructive surgery because of congenital **disease** or anomaly of a covered dependent child which has resulted in a functional defect.
- **Custodial care** or rest cures, as determined by **Medicare**.
- Eyeglasses (including contact lenses), hearing aids and examination for the prescription or fitting thereof.
- Foot care relating to corns; calluses; fallen arches; weak feet; chronic foot strain; or symptomatic complaint of the feet, unless payable by **Medicare** for the treatment of **disease** or **injury**.
- **Illness**, treatment or medical conditions resulting from war or an act of war.
- Prescription Drugs, including drugs reimbursable under **Medicare Part D**; with the exception of the limited number of prescription drugs that are payable under **Medicare Part B**.
- Routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except those considered an allowable **Medicare** expense.
- Treatment provided in a government **hospital**, unless a person must pay for it;
- Treatment provided under any state or federal Workers' Compensation, employers' liability, or similar law.
- Treatment provided under any mandatory auto "no-fault" law.
- Services and supplies rendered in the home that are not a covered **Medicare** expense.]

[Pre-existing Conditions Exclusions and Limitations

If there is a waiting period under the plan, the time used to satisfy the waiting period will be credited to the **pre-existing condition** limitation period.

For the first 365 days following your Enrollment Date, covered medical expenses do not include any expenses for treatment related to a **pre-existing condition** that manifested itself during the 180-day period immediately preceding your Enrollment Date.

For the first 365 days following your Enrollment Date, covered medical expenses incurred during the 180-day period immediately preceding a person's Enrollment Date for treatment of a **pre-existing condition** include only the first $ 1,000 - $ 10,000 of such covered medical expenses for which no benefit is payable.

Coverage will be provided subject to a 50% **coinsurance** for the treatment of a **pre-existing condition** during the first 365 days following your effective date of coverage.

Enrollment Date means your effective date of coverage under this *Booklet-Certificate* (or, if applicable, a prior plan of the **Policyholder.**

Special Rules As To A Pre-existing Condition

The **pre-existing condition** exclusion period will be reduced by the number of days of prior **creditable coverage** you have as of your effective date of coverage. Any period of **creditable coverage** will not be counted if after such period and before your enrollment date, there is a gap of 63-90 days or more where you had no **creditable coverage**. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

If you had **creditable coverage** and such coverage terminated within 63-90 days prior to your effective date of coverage, then any limitation as to a **preexisting condition** under this coverage will not apply to you.

As used above: "**creditable coverage**" means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Creditable coverage** is defined in the *Glossary*.]

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends

Your coverage under the plan will end if:

[• The plan is discontinued;
§ You voluntarily stop your coverage;
§ The group policy ends, or if the former employer ceases to be a **Participating Employer**;
§ You are no longer eligible for coverage as set forth by the eligibility requirements of the **Policyholder**;
§ You do not make any required contributions;
§ You become covered under another medical plan offered by **the Policyholder**;
§ You are no longer enrolled in **Medicare Parts A and B**;
§ You resume your employment with a **Participating Employer**. In such event, coverage will end as of the date you resume such employment and are no longer eligible to participate on the **Participating Employer's** retirement benefit program;
§ You are no longer eligible for dependents coverage. In this case, coverage ends at the end of the calendar month following the calendar month when you no longer meet the plan's definition of a dependent;
§ You do not make the required contribution toward the cost of dependents' coverage; or
§ You become eligible for comparable benefits under this or any other group plan offered by the **Policyholder**.

It is the **Policyholder's** responsibility to let **Aetna** know when your coverage ends. The limits above may be extended only if **Aetna** and the **Policyholder** agree, in writing, to extend them.]

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, the **Policyholder** is required to give you a certificate of **creditable coverage** when your coverage ends. This certificate proves that you were covered under such coverage. Ask the **Policyholder** about the certificate of **creditable coverage**.

Continuation of Coverage

Continuing Health Care Benefits

[Continuing Coverage After the Death of the Covered Retired Employee

If the **covered retired employee** should die while you are enrolled in this plan, your health care coverage will continue as long as:

§ The **covered retired employee** was covered under an **Aetna** group plan offered by the **Policyholder** at the time of death;
§ The **covered retired employee's** coverage, at the time of death, was not being continued after coverage has ended, as provided in the *When Coverage Ends* section;
§ A request is made for continued coverage within 31 days after the death of the **covered retired employee**; and
§ Payment is made for the coverage.

Your continued coverage will end when the first of the following occurs:

§ The end of the 12 month period following the death of the **covered retired employee**;
§ You no longer meet the requirements to be in an Eligible Class as described in the *Eligibility* section of this *Booklet-Certificate*;
§ Dependent coverage is discontinued under the group policy;
§ You become eligible for comparable benefits under this or any other group plan; or
§ Any required contributions stop; or
§ If you are a spouse of the **covered retired employee**, the date you remarry.

If you are a dependent of a **covered retired employee** and your coverage is being continued, a child born after the death of the **covered retired employee** will also be covered if in an Eligible Class.]

Extension of Benefits

If your health benefits end while you are totally disabled, your health expenses incurred in connection with the **injury** or **illness** that caused the total disability will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

§ You are prevented from engaging in most of the normal activities of a healthy person of the same sex or gender.

Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Extension of benefits will end on the first to occur of the date:

§ You are no longer totally disabled, or become covered under any other group plan with like benefits.
§ With respect to inpatient coverage, the 365 additional **hospital** day maximum has been reached

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage

If the **Policyholder** is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or your family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you become eligible, the **Policyholder** will provide you with detailed information on continuing your health coverage through COBRA.

You [or the **covered retired employee**] will need to:
§ Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
§ Submit your application within 60 days of the qualifying event, or within 60 days of the **Policyholder**'s notice of this COBRA continuation right, if later.
§ Agree to pay the required contributions.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	**Covered Persons Eligible to Elect Continuation**	**Maximum Continuation Periods**
[You are a **covered retired employee** and your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your covered dependents	36 months
You are a **covered retired employee** and your covered dependent children no longer qualify as dependents under the plan	Your covered dependent children	36 months

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
You are a **covered retired employee** and you die	Your covered dependents	36 months
You are a **covered retired employee** eligible for health coverage and the **Policyholder** files for bankruptcy	You and your covered dependents	18 months]

Disability May Increase Maximum Continuation to 29 Months

If You Are Disabled

If you qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you:

- Must notify the **Policyholder** within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the **Policyholder** within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

If you are a covered dependent of the **covered retired employee,** you could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.]

Determining Your Contributions For Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 [or 36 month] periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- The **Policyholder** is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You reach the maximum COBRA continuation period – the end of the 18, 29 [or 36] months. [(If you are a newly acquired dependent of the **covered retired employee** who has been added for the balance of a continuation period, you coverage would end at the same time the continuation period ends, unless you are not disabled or eligible for an extended maximum).]
- You do not pay required premiums.
- You become covered under another group plan that does not restrict coverage for **pre-existing conditions**. If your new plan limits **pre-existing condition** coverage, the continuation coverage under this plan may remain in effect until the **pre-existing** clause ceases to apply or the maximum continuation period is reached under this plan.
- The date the **Policyholder** no longer offers a group health plan.
- The date you become enrolled in benefits under **Medicare**. This does not apply if it is contrary to the **Medicare** Secondary Payer Rules or other federal law.
- You die.

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations and Evaluations

If **Medicare Part A** or **Part B** benefits are exhausted or a service or supply is not covered under **Medicare**, and the services or supplies being requested by the covered person require pre-certification, **Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit [after 3 years] from the deadline for filing claims.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for [your care or treatment,] the operation of the plan and administration of this *Booklet-Certificate*, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s Notice of Information Practices by [calling **Aetna**'s toll-free Member Service telephone.]

Additional Provisions

The following additional provisions apply to your coverage:

- This *Booklet-Certificate* applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer or **Policyholder**.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the group policy. If you have any questions about the terms of the plan or about the proper payment of benefits, contact [the **Policyholder**] or **Aetna**.
- [The **Policyholder**] hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to a provider or facility including but not limited to, an assignment of:

- The benefits due under this contract;
- The right to receive payments due under this contract; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this contract.

Misstatements

If any fact as to [the **Policyholder** or you] is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by [the **Policyholder** or you] shall be deemed representations and not warranties. No written statement made by [you] shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to [you or your] beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna**'s right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the **Policyholder** or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by the **Policyholder** shall be the basis for voiding this Contract after it has been in force for 2 years from its effective date.
- [No statement made by you, an eligible **retired employee** and/or their or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.]

Subrogation and Right of Reimbursement

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries**." "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries**.

If this plan pays benefits under this **Certificate** to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries**. **Aetna**'s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence.

By accepting benefits under this plan, you specifically acknowledge **Aetna**'s right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, **Aetna** shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. **Aetna** may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**'s right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this **Certificate**, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. **Aetna**'s right of reimbursement is cumulative with and not exclusive of **Aetna**'s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**'s rights of subrogation and reimbursement under this **Certificate**;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**'s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this *Booklet-Certificate* without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**. In the event you or you representative fails to cooperate with **Aetna**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

Worker's Compensation

If benefits are paid by **Aetna** and **Aetna** determines you received Worker's Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna w**ill exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this contract, you will notify **Aetna** of any Worker's Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this Contract and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss and must include the **Explanation of Benefits** from **Medicare** in response to the claim. All claims should be reported promptly. The deadline for filing a claim with **Aetna** for any benefits is [90] days after the **Medicare Explanation of Benefits** form is received by the claimant. Failure to give such proof within that time will not affect a claim if such proof is provided within one year after the loss occurs, unless you are legally incapacitated. Further written proof must be given to **Aetna** when requested.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

§ Names of **physicians**, **dentists** and others who furnish services.
§ Dates expenses are incurred.
§ Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Administrator at:

[Aetna Administrator[
Aetna Life Insurance Company
Address of our selected vendor]

You may also use **Aetna**'s toll free [Member Services] phone number: [1-800-xxx-xxxx] or visit **Aetna**'s web site at [www.**Aetna**.com.]

Reinstatement of Coverage
If your coverage ends, you may again become covered in accordance with the terms of this plan.

Discount Programs

Discount Arrangements
From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and health living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render though discount arrangements.

Glossary

[The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the *Glossary*, the definition in the benefit section will apply in lieu of the definition in the *Glossary*.

Terms defined here appear in **bold type** throughout the text of this *Booklet-Certificate*.

A

Aetna
Aetna Life Insurance Company

B

Benefit Period
This means a period of time as determined under **Medicare**. For **hospital** confinements and **skilled nursing facility** confinements, a **benefit period** starts on the first day of confinement of the covered person as an inpatient. It ends when the covered person has been out of the **hospital** or **skilled nursing facility** for 60 consecutive days including day of discharge.

Board and Room Charges
Charges made by an institution for **board and room** and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

C

Coinsurance Amount
Means the percentage of **Medicare** eligible expenses after the **deductible** which the covered person must pay. [The **coinsurance amount** does not include the excess over **reasonable costs**, as determined by **Medicare**.]

Covered Expenses
Medical or dental services and supplies shown as covered under this *Booklet-Certificate*.

Covered Retiree/Retired Employee
Means a retired employee of the **Policyholder** who is eligible for and enrolled in this plan, as described in the *Eligibility* section of the *Booklet-Certificate*; or is eligible for and enrolled in another **Aetna** retiree health plan offered by the **Policyholder**.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- **Medicare**;
- **Medicaid**;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
As defined under **Medicare**.

D

Deductible
The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist
A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Disease
Means an **illness** or sickness of a covered person which first manifests itself after the effective date of his or her coverage and while this plan is in force.

[Durable Medical and Surgical Equipment
As defined under **Medicare**.]

E

Emergency Care
This means the treatment given in a **hospital**'s emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Excess Fees
As defined under **Medicare**.

Explanation of Benefits
Means the detailed accounting of benefits covered and paid by the plan.

H

Hospital
Means an institution which is certified or certifiable under **Medicare** as a provider of **hospital** services.

Hospitalization
Is necessary and continuous confinement as an inpatient in a **hospital** is required and a charge for **room and board** is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

L

Lifetime Reserve Days
Means the 60 inpatient **hospital** days after the 90th day of a **hospital** confinement for which **Medicare** pays benefits. Only 60 such days in total are available to the covered person from **Medicare** during the covered person's lifetime. **Medicare** allows the covered person to choose when reserve days are used.]

M

Medically Necessary
A service or supply furnished by a particular provider is **medically necessary** if determined by **Medicare** to be appropriate for the diagnosis, the care or the treatment of the **disease** or **injury** involved.

[Medicaid
Means the **Medicaid** program under Title XIX of the Social Security Act (**Medicaid**), as amended.]

Medicare
Means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Part A
Means that part of **Medicare** that pays for **hospital** insurance benefits, including inpatient **hospital** care, care in a **skilled nursing facility**, some **home health care agency** care and **hospice care** offered through **Medicare**.

Medicare Part B
Means **Medicare** supplementary medical insurance that is optional and requires a monthly premium. **Medicare Part B** covers **physician**s services (in both **hospital** and non-**hospital** settings) and services furnished by certain non-**physician** practitioners. Other **Medicare Part B** services include lab testing, **durable medical equipment**, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under **Medicare Part A**.

Medicare Part D
Means that part of **Medicare** that pays for outpatient prescription drug expenses. **Medicare Part D** coverage is not available through the plan of benefits described in this **certificate**.

P

[Participating Employer
Means member employers of an employer networking consortium which has contracted with **Aetna** to provide group employer coverage for **retired employees** and who have elected and been accepted to purchase, or arrange for the purchase of, one or more **Aetna** plans.]

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A **physician** is not you or related to you.

Policyholder

An employer or organization which agrees to remit the premiums for coverage under the policy payable to **Aetna**. The **Policyholder** shall act only as an agent of covered person in the **Policyholder's** group, and shall not be the agent of **Aetna** for any purpose.

Pre-existing Condition

A **pre-existing condition** is an **illness** or **injury** for which, during the [180] day period immediately prior to your enrollment date:

- Medical treatment, services, or supplies were received or prescription drugs or medicines were taken
- [or medical advice, diagnosis, care, or treatment was recommended or received].

The **pre-existing condition** limitation does not apply to

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child becomes covered under **creditable coverage** within 31 days of birth, adoption, or placement of adoption;
- Genetic information will not be treated as a **pre-existing condition** in the absence of a diagnosis of the condition related to that information.
- Pregnancy will not be treated as a **pre-existing condition**.

R

Reasonable Cost

Only that part of a charge which is reasonable is covered. A charge for a service or supply is reasonable to the extent it is allowable by **Medicare**.]

[Retiree Health Access (RHA) Program

A program established by the Health Care Policy Roundtable, LLC (HCPR) to facilitate the provision of cost-effective health insurance to **retirees** of large employers who are members of the HR Policy Association (HRPA) or the Pacific Business Group on Health (PBGH).]

S

Skilled Nursing Facility

This is an institution which is certified or certifiable under **Medicare** as a provider of **skilled nursing facility** services.

Appeals Procedure

[Definitions
Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.]

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.]

Claim Determinations

[Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.]

[Pre-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.]

[Post-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.]

[Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **Aetna** will make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.]

[Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.]

[Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must write **Aetna** Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.]

[Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted verbally or in writing and should include:

- Your name;
- Your the **Policyholder**'s name;
- A copy of **Aetna**'s notice of an adverse benefit determination;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

The notice of an **adverse benefit determination** will include the address where the **appeal** can be sent. If your **appeal** is of an urgent nature, you may call **Aetna's** Customer Service Unit at the toll-free phone number on your ID card.]

[You may also choose to have another person (an authorized representative) make the **appeal** on your behalf by providing verbal or written consent to **Aetna**.]

[Level One Appeal - Group Health Claims

A level one **appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.]

[You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the **adverse benefit determination** will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.]

[Level Two Appeal

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the right to file a level two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of notice of a level one **appeal**.

A level two **appeal** of an **adverse benefit determination** of an **urgent care claim**, **a Pre-Service Claim**, **or a Post-Service Claim** shall be provided by **Aetna** personnel not involved in making an **adverse benefit determination**.

Urgent Care Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal**.

Pre-Service Claims (May Include **concurrent care claim reduction or termination**)
Aetna shall issue a decision within 15 calendar days of receipt of the request for level two **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two **appeal**.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.]

[Exhaustion of Process
You must exhaust the applicable Level one and Level two processes of the **Appeals** Procedure before you:

§ Establish any:
  – litigation;
  – arbitration; or
  – administrative proceeding;]

[regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the **Appeals** Procedure.]

[Health Claims – Voluntary Appeals

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

If you file a voluntary **appeal**, any applicable statute of limitations will be tolled while the **appeal** is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the **appeal** is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.]

[External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is **experimental or investigational** in nature. In either of these situations, you may request an external review if you or your provider disagrees with **Aetna's** decision. An external review is a review by an independent **physician**, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

§ You have received notice of the denial of a claim by **Aetna**; and
§ Your claim was denied because **Aetna** determined that the care was not necessary or was experimental or investigational; and
§ The cost of the service or treatment in question for which you are responsible exceeds $500; and
§ You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of **Aetna's** receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after **Aetna** receives the request.

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to **Aetna**. **Aetna** is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.]

[For more information about **Aetna's** External Review process, call the toll-free Customer Services telephone number shown on your ID card.]

Schedule of Benefits

[Policyholder: ABC Company]
[Group Policy Number: XXXXXX]
Issue Date: [January 1, 20XX]
Effective Date: [January 1, 20XX]
[Schedule: 1A
Booklet Base: 1]
This is an ERISA plan, and you have certain rights under this plan. Please contact the **Policyholder** for additional information.

NOTE: You must use a health care provider that is eligible to receive reimbursement under Medicare in order to receive benefits under this Plan. This Plan covers only Medicare approved charges, up to the Medicare allowable amount unless noted in this Schedule of Benefits.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET-CERTIFICATE.

[Deductible Provisions

Calendar Year Deductible
This is an amount of **covered expenses** you incur each Calendar Year for which no benefits will be paid. After **covered expenses** reach the Calendar Year **deductible**, the plan will begin to pay benefits for your **covered expenses** for the rest of the Calendar Year.]

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense.

[Calendar Year Out-of-Pocket Maximum
The **Out-of-Pocket Maximum** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Out-of-Pocket Maximum**, the plan will pay 100% of your **covered expenses** that apply toward the limit for the rest of the Calendar Year.

Expenses That Do Not Apply to Your Out-of-Pocket Maximum
Certain **covered expenses** do not apply toward your plan **Out-of-Pocket Maximum**. These include:

§ Charges over the **recognized cost**;
§ Non-covered expenses.]

HEALTH EXPENSE COVERAGE
PLAN FEATURES
This Plan provides for automatic adjustment of benefits necessary to cover changes in the [coinsurance amount, deductible or coverage requirements] of the Medicare program. Changes to Part A and Part B of Medicare are generally announced in October to take effect on the first day of January of the following calendar year. Aetna will provide notice of any resulting changes in benefits or premium contributions. Any changes required will become effective on the effective date of the change in the Medicare program.
[Calendar Year Deductible Amount $1,000 - $10,000]

[Benefits will not begin until out-of-pocket **deductible** expenses of $1,000 - $10,000 are met. Out-of-pocket expenses for this **deductible** are expenses that would ordinarily be paid by the policy. This includes the **deductibles** for **Medicare Part A** and **Medicare Part B**, but does not include the plan's separate foreign travel emergency **deductible**.]

[Calendar Year Out-of-Pocket Maximum $2,310 to $15,000]

[Once you reach the calendar year out-of-pocket maximum, the plan pays 100% of your **Medicare copayment** and **coinsurance** for the rest of the calendar year. **This limit does NOT include charges for Part B "Excess Charges." You are responsible for that amount.]**

The Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount Aetna pays. You are responsible to pay any deductibles, and the remaining Payment Percentage. You are responsible for full payment of any non-covered expenses you incur.

[All Covered Expenses Are Subject To The Calendar Year Deductible Amount Unless Otherwise Noted In The Schedule Below.]

PLAN FEATURES
[MEDICARE PART A] ***BENEFIT***

[Inpatient Hospitalization – Per Benefit Period

A **benefit period** begins on the first day you receive care as an inpatient in a **hospital** and ends after you have been out of the **hospital** and have not received skilled care in any other facility for 60 days in a row, including the day of discharge.

Semi-private **board and room**, general nursing and miscellaneous services and supplies.

Days 1 through 60:	An amount equal to 100%-50% of the **Medicare Part A** deductible
	Not Covered
Days 61 through 90:	An amount equal to the portion of the daily **board and room** charges not covered by **Medicare**
Days 91 and after:	
While using 60 lifetime reserve days:	An amount equal to the portion of the daily **board and room** charges not covered by **Medicare**
Once Lifetime Reserve Days have been used:	
Additional 365 days	100% of **Medicare**-eligible expenses
Beyond the Lifetime Maximum 365 days	Not Covered]

[Inpatient Care in Medicare Certified Psychiatric Facility

190 days lifetime]

[Skilled Nursing Facility Care – Per Benefit Period

You must meet **Medicare's** requirements, including having been in a **hospital** for at least 3 days and entered the **Medicare**-approved facility within 30 days after leaving the **hospital**.

A **benefit period** begins on the first day you receive care as an inpatient in a **hospital** and ends after you have been out of the **hospital** and have not received skilled care in any other facility for 60 days in a row, including the day of discharge.

First 20 days	Not Covered
21st through 100th day	An amount equal to 100%-50% of the charges not covered by **Medicare.**
Days 101 and after	Not Covered]

[Blood

First 3 pints or equivalent quantities of packed red blood cells	100% of **reasonable cost**, as defined under the federal regulations, unless replaced in accordance with federal regulations.]

[MEDICARE PART B

MEDICAL SERVICES	*BENEFIT*

Includes services such as **physicians**' services, inpatient and outpatient medical and surgical services and supplies, **durable medical equipment**, physical and speech therapy, outpatient mental health and diagnostic tests.]

[First $135 of **Medicare** approved amounts:	Not Covered
	An amount equal to the Medicare Part B **deductible**.*

You are responsible for meeting the **Medicare Part B deductible** before the plan will pay benefits.

*Once you have been billed $135 of **Medicare**-approved amounts for **covered expenses**, your **Medicare Part B deductible** for the calendar year has been met.]

[Remainder of **Medicare** Approved Amounts:	The amount equal to 100%-50% of the charges not covered by **Medicare**.]
[**Blood** First 3 pints or equivalent quantities of packed red blood cells	100% of **reasonable cost**, as defined under the federal regulations, unless replaced in accordance with federal regulations.]
[Hospice Care	The amount equal to 100%-50% of the charges not covered by **Medicare.**]

[PART B EXCESS FEES *BENEFIT*

(The difference between the **Medicare Part B** eligible expenses and the charge actually made by **your** health care provider that does not take	Not Covered

assignment with **Medicare)**	100%-80%]

[Foreign Travel Emergency
Medically necessary **emergency care** services, which commence during the first 60 days of a trip outside the USA.

First $250 each calendar year:	Not Covered
Remainder of **covered expenses**:	100%-50% to a lifetime maximum benefit of $50,000]

Medicare benefits are subject to change. Please consult 1-800-MEDICAR or www.medicare.gov for the latest information.

General

This *Schedule of Benefits* replaces any similar *Schedule of Benefits* previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this *Schedule of Benefits* cannot be accepted. This *Schedule of Benefits* is part of your *Booklet-Certificate* and should be kept with your *Booklet-Certificate*.

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*41861*
Company Tracking Number:	*GH AR0150001F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Retiree Markets*		
Project Name/Number:	*2009 Retiree Markets/GH AR0150001F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*41861*
Company Tracking Number:	*GH AR0150001F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Retiree Markets*		
Project Name/Number:	*2009 Retiree Markets/GH AR0150001F01*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 03/25/2009
Comments:
Attachment:
Officer Certification.PDF

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 03/25/2009
Bypass Reason: N/A
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 03/25/2009
Bypass Reason: N/A
Comments:

Satisfied -Name: CERTIFICATE EOV
Review Status: Approved-Closed 03/25/2009
Comments:
Attachment:
CERTIFICATE EOV.PDF

Satisfied -Name: SCHEDULE OF BENEITS EOV
Review Status: Approved-Closed 03/25/2009
Comments:
Attachment:
SCHEDULE OF BENEITS EOV.PDF

Satisfied -Name: Attachment A
Review Status: Approved-Closed 03/25/2009
Comments:
Attachment:

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*41861*
Company Tracking Number:	*GH AR0150001F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Retiree Markets*		
Project Name/Number:	*2009 Retiree Markets/GH AR0150001F01*		

Attachment A.PDF

SERFF Tracking Number:	*AENX-126079802*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*41861*
Company Tracking Number:	*GH AR0150001F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Retiree Markets*		
Project Name/Number:	*2009 Retiree Markets/GH AR0150001F01*		

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 03/25/2009

Comments:

Attachment:

Cover Letter.PDF

Satisfied -Name: NAIC Transmittal **Review Status:** Approved-Closed 03/25/2009

Comments:

Attachment:

NAIC Transmittal.PDF

Satisfied -Name: NAIC Form Listing **Review Status:** Approved-Closed 03/25/2009

Comments:

Attachment:

NAIC Form Listing.PDF

Satisfied -Name: Application **Review Status:** Approved-Closed 03/25/2009

Comments:

Aetna is utilizing employer application form GR-23-7 which was approved by the department on 11/17/2005.

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Aetna Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GR-9N-GM 01-005 01	41.7
GR-9N-GM S-10-01	0

Signed: Stephen W. Halloran

Name: Stephen W. Halloran

Title: Assistant Vice President

Date: March xx, 2009

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
01-000

General Comments

The forms contain illustrative policyholder information, (e.g., addresses, phone numbers) and variable material set forth in brackets. Variability is required so that only the applicable and appropriate text will be included in a policyholder's plan documents upon issue. Any changes in language in these sections would be only in response to a policyholder's request to customize the wording to the extent permitted by any applicable state law or regulation, and to revise the terminology due to the type of customer and eligible class, (e.g., "employer" to "policyholder", "retiree" to "covered person"). Any change to the text will not result in a departure from the intent and purpose of a provision and will be in full compliance with any applicable state laws and regulations.

The placement of the material will vary to avoid gaps and to allow the plan documents to be system-produced.

Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description or the payment of benefits or other terms and conditions of the group policy, may vary as the sense may demand.

The sequence of the sections and provisions may vary.

References to dependents coverage are variable. If dependents coverage is not part of the Policyholder's plan, all references to dependents will be omitted and the text will be modified appropriately.

The references to Schedule of Benefits may be changed to Summary of Benefits. The terms "you" or "your" may be changed to reflect the eligible class or classes, (e.g., "employee", "retired employee." "covered person").

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
29-005

Determining if You Are in an Eligible Class

This section will be structured to reflect the specifics of a policyholder's plan. The appropriate entity references to the policyholder (e.g. employer, association) will be included. The classes of persons eligible to enroll in a policyholder's plan will vary and will be reflected throughout this section. The eligible class and the eligibility dates are determined by the policyholder in compliance with federal and state requirements and mutually agreed upon with Aetna.

Initial Enrollment in the Plan

In the first paragraph of this section, the language mentioning contributions from a person's pay may be changed to say, for example, "pension payment" rather than pay. If contributions are not deducted from a person's pay, this wording will not appear.

In the second paragraph of this section, the 31 day enrollment period will be increased when the policyholder has a longer enrollment window.

Loss of Other Health Care Coverage
Under the last bullet of this section, the 31 day enrollment period will be increased when the policyholder has a longer enrollment window.

New Dependents

When included, the 31 day enrollment period in the second paragraph of this section will be increased when the policyholder has a longer enrollment window.

If you Adopt a Child

When included, the 31 day enrollment period under the second bullet of this section will be increased when the policyholder has a longer enrollment window.

When You Receive a Qualified Child Support Order

Under the second bullet of this section and the third full paragraph, the 31 day enrollment period under will be increased when the policyholder has a longer enrollment window.

Your Effective Date of Coverage

This section will be structured to reflect the specifics of a policyholder's plan. The appropriate entity references to the policyholder (e.g. employer, association) will be included. The types of classes and individuals eligible to enroll in a policyholder's plan will vary and will be reflected throughout this section. The eligible class and the eligibility dates are determined by the policyholder in compliance with federal and state requirements and mutually agreed upon with Aetna. These are examples of when a person's eligibility date may be defined.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
29-005

Your Dependent's Effective Date of Coverage

When included, this section will be structured to reflect the specifics of a policyholder's plan. The individuals eligible to enroll in a policyholder's plan will vary and will be reflected throughout this section. The eligibility dates are determined by the policyholder in compliance with federal and state requirements and mutually agreed upon with Aetna. These are examples of when a person's eligibility date may be defined.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
08-005

How Your Medical Plan Works

Important Notes

When a covered person's allowable expenses for emergency care while engaged in foreign travel are expended, the plan may, in come cases, cover additional costs for this benefit. If so, this section will be included.

Using the Plan

This section will be included when the plan includes the noted cost-sharing features; the covered person will received the explanation of benefits description referenced in this section.

Cost Sharing

The language mentioning the deductible appearing in the first and second bullets of this section will be included when the policyholder's plan includes a deductible.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
27-005

In Case of a Medical Emergency

Follow-Up Care After Treatment of an Emergency Medical Condition

These sections may be included when the policyholder's plan includes coverage for emergency care in foreign countries.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
10-005

What the Plan Covers

Health Expense Coverage

The reference to a deductible will be included when the policyholder's plan includes this feature.

Notes -- When a covered person's allowable expenses for emergency care while engaged in foreign travel are expended, the plan may, in come cases, cover additional costs for this benefit. If so, these segments will be included.

Coinsurance, Deductible or Coverage Requirements – This segment will be included when the policyholder's plan is one which follows the Medicare plan services, supplies and cost-sharing features closely.

Covered Expenses

This section will vary to show the actual list of expenses that are included under a policyholder's plan of benefits.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
28-005

Medical Plan Exclusions

This page is variable to allow for: (1) the removal of certain exclusions for which a specific policyholder may wish to include coverage; and (2) the modification of certain exclusions to allow the policyholder to contract the scope of the exclusions. In no event will any change result in a provision that:

- is not in compliance with any applicable law or regulation; or
- departs from the intent and purpose of that provision as approved by your Department.

Preexisting Conditions Exclusions and Limitations

This section will be included upon election of the policyholder. When included it will be revised as follows:

- The policyholder may elect to reduce either or both the look back and carry forward periods.
- The policyholder may elect to provide no coverage for a pre-existing condition.
- The policyholder may elect to provide coverage up to a maximum dollar amount for pre-existing conditions. When included, the dollar amount [will vary within the range shown] [may be reduced].
- The policyholder may elect to provide a 50% benefit for pre-existing conditions.

Either of the two options shown will be included:

- Either the option that reduces the time period for the pre-existing condition limitation by the amount of days the enrollee has credible coverage; or
- The option that waives the entire time period for the pre-existing condition limitation by if the enrollee has had any credible coverage.

Under both of the above options the time frame applicable to the gap in coverage [will vary within the range shown] [may be reduced].

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
30-005

When Coverage Ends

This section will be structured to reflect the specifics of a policyholder's plan. The appropriate entity references to the policyholder (e.g. employer, association) will be included. The reasons for termination of coverage will be in compliance with federal and state requirements.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
GR-9N-GM
31-005

Continuing Coverage After the Death of the Retired Employee

This section may be included only if dependent coverage is available under a policyholder's plan. The 31 day enrollment period in the third bullet of this section will be increased when the policyholder has a longer enrollment window. The reasons for termination of the continued coverage will be structured to reflect the specifics of a policyholder's plan. The reasons for termination of coverage will be in compliance with federal and state requirements. The 12-month maximum limit may be changed to increase the period of time available for the continuation.

Extension of Benefits

References to injury or illness that caused the disability may be omitted. The periods of the extensions will be included as shown or may be increased.

COBRA Continuation of Coverage

This segment will be included when COBRA applies to a policyholder's plan. If COBRA does apply, all references appropriate pursuant to current Federal law will be shown. References to dependents and applicable time frames will be included when dependent coverage is provided under the policyholder's plan.

Aetna Life Insurance Company
Explanation of Variability
Certificate of Coverage
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32-005

Legal Action

The three year time period may be increased.

Confidentiality

The wording "your care or treatment" may be revised to note "pay a claim" or some other relevant phrase. The reference to the toll free number may be revised to direct the member to the telephone number on their ID card. In addition, the term "Member Services department" may change or may reflect name of Aetna's selected vendor.

Incontestability

The third bulleted item may be modified to reflect a longer or shorter time period, as allowable by state law.

Contacting Aetna

With the exception of the name of the underwriting company, this contact information may change.

Aetna Life Insurance Company
Explanation of Variability
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34-005

Glossary

A definition may change to reflect appropriate terminology and the benefits described. For example, the words "precertification" may be changed to "preauthorization" or another term of similar meaning. References to "calendar year" may be changed to "benefit year", "plan year" or "benefit term".

If a term is changed (e.g. "injury" to "accidental injury"), then that defined term will be integrated under the appropriate alphabetical listing. The definitions shown in brackets will be included when applicable to a policyholder's plan. The language used in the definition may be customized, in response to a policyholder's request, without changing the meaning. In no event, however, will any change result in a provision that:

- is not in compliance with any applicable law or regulation; or
- departs from the intent and purpose of that provision as approved by your Department.

Coinsurance Amount

The bracketed sentence will be included when applicable to the specifics of the policyholder's plan.

Durable Medical Equipment

The definition will be included if this benefit is included in the policyholder's plan.

Medicaid

This definition will appear when applicable to the policyholder's plan.

Participating Employer

This definition may be revised to accommodate changes in the terms of a policyholder's participation in a consortium of member employers.

Pre-existing Condition

The look back period may be revised to accommodate the specifics of the policyholder's plan, as permitted under state law. The criteria used to determine whether or not a pre-existing condition has been recognized may be revised or omitted, as permitted under state law.

Retiree Health Access (RHA) Program:

This definition will only appear in certificates distributed under group policies issued directly to participating employers of the RHA Program.

Aetna Life Insurance Company
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01

Appeals

The plan of benefits for this product include only those services and supplies that are covered by Medicare and then, only for the amount that is not covered by Medicare. As a result, the Federal Medicare administrator will be the primary first contact for covered persons regarding appeals.

When Medicare benefits are exhausted and the Aetna plan is the primary coverage option, the guidelines presented in this amendment will be utilized.

Only those provisions that apply for coverage based upon Medicare services and supplies will be included.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
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S-10-01
01

General

Terms:

- The term "Schedule of Benefits" may be changed to "Summary of Benefits".
- The term 'calendar" may be changed to "plan, policy, 365 consecutive day period, or 12 consecutive month period".

Variable Benefits

The benefits shown on this Schedule encompass all the variables that may be marketed and sold to the policyholder. The specifics will vary to reflect the current amounts applicable under Medicare and the amount of coverage selected by the policyholder for the Medicare-eligible benefits listed. The policyholder's final Schedule of Benefits will reflect only the benefits, cost-sharing, specific benefit maximums and limits as applicable to the policyholder's plan design.

The Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum sections will be included when applicable to the policyholder's plan, and the amounts will vary to reflect the specific requirements of a policyholder's plan but will never be greater than the amounts shown in the submitted form.

Health Expense Coverage

Plan Features

The bracketed cost-sharing references will be included to reflect the specifics of the policyholder's plan.

Calendar Year Deductible Amount

This item will be included when the policyholder's plan has a calendar/plan year deductible. When included, the amount will vary within the range shown.

Calendar Year Out-of-Pocket Maximum

This item will be included when the policyholder's plan has an out-of-pocket maximum. When included, the amount will vary within the range shown.

Covered Expenses for which the Calendar Year Deductible Applies

This sentence will be included or omitted according to the specifics of the policyholder's plan.

Aetna Life Insurance Company
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Schedule of Benefits
GR-9N-GM
S-10-01
01

Inpatient Hospitalization – Per Benefit Period
When this benefit is included under a policyholder's plan, the components of this coverage will be included according to the specifics of the policyholder's plan. The covered percentages will vary within the ranges shown.

Inpatient Care in Medicare Certified Psychiatric Facility
When this benefit is included under a policyholder's plan, the lifetime limit may be increased to accommodate the specifics of the policyholder's plan.

Skilled Nursing Facility Care – Per Benefit Period
When this benefit is included under a policyholder's plan, the components of this coverage will be included according to the specifics of the policyholder's plan. The covered percentages will be within the ranges shown.

Blood
When this benefit is included under a policyholder's plan, the covered percentage will be within the range shown according to the specifics of the policyholder's plan.

Medical Services

Medical Services Covered Amounts
When this benefit is included under a policyholder's plan, the components of this coverage will be included according to the specifics of the policyholder's plan. The covered percentages will vary within the ranges shown.

Blood
When this benefit is included under a policyholder's plan, the covered percentage will be within the range shown according to the specifics of the policyholder's plan.

Hospice Care
When this benefit is included under a policyholder's plan, the covered percentage will be within the range shown according to the specifics of the policyholder's plan.

Part B Excess Fees
When this benefit is included under a policyholder's plan, the covered percentages will be within the ranges shown according to the specifics of the policyholder's plan.

Foreign Travel Emergency
When this benefit is included under a policyholder's plan, the components of this coverage will be included according to the specifics of the policyholder's plan. The covered percentages will vary within the ranges shown.

ATTACHMENT A

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Doreen M. Gatley
Product & Regulatory Approvals
Law & Regulatory Affairs
151 Farmington Ave., RE6A
Hartford, CT 06156
(860) 273-7848 or (800) 872-3862
Fax Number: 860-754-9278

GatleyD@aetna.com

March 18, 2009

Insurance Commissioner Julie Benafield Bowman
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Subject: **Aetna Life Insurance Company – NAIC 60054**
Group Accident and Health
Booklet-Certificate Forms: GR-9N-GM 01-005 01 et. al.

Dear Ms. Benafield:

The attached group Booklet-Certificate forms are being submitted to your Department, for review and approval on a general use basis. Attachment A of this letter identifies each form that is enclosed. These forms are new and are not intended to replace any form currently on file with the Department. These forms are in final printed format and are neither drafts nor proofs.

The enclosed forms are intended to be used with Group Life, Accident and Health insurance policy form GR-29N approved by your Department on June 23, 2006.

On February 13, 2009, Mandana Shahvari Counsel for Aetna, and Gregg Martino, Head of State Government Relations of Aetna, met with Dan Honey, Deputy Commissioner to discuss the general concept of this new retiree group health product filing. As was explained to Mr. Honey, this new group health product will be offered to retirees and their eligible dependents who are enrolled in Medicare and the product will offer benefits that exactly mirror certain standardized Medigap plan designs (Group "Medigap" Type product). The purpose of our discussion with Mr. Honey was to confirm whether benefit mandates would be deemed to apply to this new Group Medigap Type product.

As a result of this discussion, Mr. Honey, suggested that we submit the filing for this new product to the Department (recognizing that Aetna would submit the product

without benefit mandates) along with information in support of our position that benefit mandates should not apply. Therefore, you will find that the enclosed filing does not include benefit mandates, pursuant to Arkansas §§23-79-801 through 804. We are submitting the analysis set forth below in support of this filing for further consideration by the Department.

Background

In response to discussions with several Aetna customers regarding health plans offered to their retirees, we are working to develop and file an employer group health product that can be offered to retirees enrolled in Medicare on a national basis with a simple, straightforward and affordable plan design. Standardized Medigap plan designs fulfill this market need. Medigap plan designs have been offered for many years, and were developed with the goal of improving Medicare beneficiary decision making by simplifying options and reducing confusion. Following the standardization of Medigap plans, consumers found it easier to compare products and prices and to choose the health benefits they needed at a known cost. Over the years, choosing a Medigap policy has become one of the easiest insurance decisions Medicare beneficiaries are required to make.

However, most states, including Arkansas, follow the NAIC Model Medicare Supplement Insurance Minimum Standards Model Act ("NAIC Model"). Consistent with the NAIC Model, Arkansas' Medicare Supplement laws, rules and regulations policies **do not** apply to policies offered to employer groups. Therefore, the Medicare Supplement law in Arkansas, as in most states, exempts employer groups from the Med Supp regulatory scheme.

As an alternative to offering a "true" Med Supp plan for employer groups, we recently discussed with regulators in a number of states, including Arkansas, the possibility of offering a fully-insured employer group heath plan for retirees enrolled in Medicare with benefits that exactly mirror the standard Medigap plan designs A, B, C, F, high deductible F, K and L ("Group "Medigap" Type product"). We want to file this Group "Medigap" Type product in all 50 states and the United States territories of Puerto Rico, Guam and the U.S. Virgin Islands. We hope to offer this product with a January 1, 2010 effective in all States and United States territories.

Benefit Mandates Should Not Apply

We have confirmed with several states that Aetna will be permitted to offer this Group "Medigap" Type retiree product in their states. (Florida did not incorporate the NAIC model exemption for employer groups, so in Florida, we will have to offer a "true" group Medigap product.)

We have also reached out to several states to confirm that state benefit mandates would not apply to this Group "Medigap" Type product. Given that the product's benefits will exactly mirror the standard Medigap plan designs and will provide a limited-type of

coverage that "fills the gaps" in Medicare (just like "true" Medigap), we believe that state benefit mandates should not apply.

Aetna currently offers traditional retiree plans with comprehensive benefits that coordinate with Medicare. There is no question that state mandates should apply to these types of comprehensive plans. However, the Medigap plan designs that will form the basis of our new retiree plans provide limited benefits that are generally defined with reference to what Medicare doesn't cover. For example, Medigap plans do not provide a comprehensive benefit for physician services. Rather, depending on the particular plan design, the Medigap plans cover all or a portion of the Part B coinsurance or co-payment, and in some cases, the Part B deductible and/or Part B excess charges. They are not comprehensive benefit plans to which mandated benefit laws were intended to apply.

The standard Medigap plan designs are well understood and accepted. We are concerned that adding state-specific mandates to this product would only serve to unnecessarily complicate the product design, potentially create consumer confusion and create inconsistency in plan design for employers offering this product in multiple states. Thus far, the states of Alabama, Alaska, Connecticut, Iowa, Louisiana, Missouri, New Hampshire, New Jersey, New York, Ohio, Oregon, South Carolina, South Dakota, Virginia, Wyoming and West Virginia and the U.S Virgin Islands agreed with our analysis and confirmed that state benefit mandates would not apply to our Group "Medigap" Type product. Like Arkansas, these states are rigorous in their protection of consumers and we believe they would not provide such guidance if they were not completely persuaded that such an approach was in the best interests of Medicare-eligible retirees residing in their states.

Conclusion

For all of the reasons noted above, we believe that exempting this product from benefit mandates would further the interests of Medicare-eligible retirees residing in the State of Arkansas by offering them another clear and affordable health care option.

We appreciate the opportunity to provide the Department with further information in support of this filing. Should the Department have any questions or concerns regarding this letter, Aetna looks forward to the opportunity to answer those questions and to discuss those concerns with the Department.

The material within brackets is intended to be variable, and may be subject to omission, inclusion or change according to the needs of a particular policyholder. Upon issuance of these documents, the placement of textual material may vary to avoid gaps that would otherwise be created by the deletion of bracketed material. Coverage, sections and/or provisions may appear in sequence other than that shown. Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the group policy, may vary as the sense demands. A detailed explanation of variability has been provided with this submission.

These forms were submitted to the State of Connecticut Department of Insurance, Aetna's state of domicile and approved for use outside of Connecticut on February 12, 2009.

We appreciate the opportunity to provide the Department with further information in support of this filing. Should the Department have any questions or concerns regarding this letter, Aetna looks forward to the opportunity to answer those questions and to discuss those concerns with the Department. Please do not hesitate to contact me at the address, e-mail address or telephone number noted above.

Sincerely,

Doreen M. Gatley

Product & Regulatory Approvals Department
/Enclosures

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3. **Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT	7700013	001	60054	06-6033492	

4. **Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Doreen Gatley 151 Farmington Avenue, Mail Stop RE6A Hartford CT 06156	860-273-7848	860-754-9278	GatleyD@aetna.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	GH AR0150001F01
7.	☒ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☒ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H21 Health - Other
10.	**Product Coding Matrix Filing Code**	H21.000 Health - Other
11.	**Submitted Documents**	☒ **FORMS** ☐ Policy ☐ Outline of Coverage ☒ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☒ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	March 18, 2009
13.	**Filing Fee (If required)**	Amount $50 Check Date EFT Retaliatory ☐ Yes ☒ No Check Number
14.	**Date of Domiciliary Approval**	February 12, 2009
15.	**Filing Description:**	
	These new forms have been developed to support a product designed for retirees who have enrolled in Medicare Parts A and B for their primary health care coverage. The product design is simple in that coverage is provided for a portion of the Medicare plan's cost-sharing and for services and supplies which may be covered once Medicare limits have been exhausted. Though this is not a Medicare Supplement health plan, you will find that the plan of benefits mirrors those available in such plans.	

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Doreen Gatley Title P&RA Support Specialist

Signature Doreen M. Gatley Date March 18, 2009

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GH AR0150001F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	CERTIFICATE OF COVERAGE	GR-9N-GM 01-005 01	☒ Initial ☐ Revised ☐ Other _____	
02	SCHEDULE OF BENEFITS	GR-9N-GM S-10-01	☒ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	